House of Representatives

File No. 815

General Assembly

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(Reprint of File No. 293)

Substitute House Bill No. 7183
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 31, 2017

AN ACT CONCERNING CAPTIVE INSURANCE COMPANIES, SHORT-TERM CARE INSURANCE, PERSONAL AND COMMERCIAL RISK INSURANCE, PREFERRED PROVIDER NETWORKS, AND MAKING MINOR AND TECHNICAL CHANGES TO CERTAIN INSURANCE-RELATED STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2017*) (a) For the purposes of this section, unless the context otherwise requires:

(1) "Dormant captive insurance company" means a pure captive insurance company, a sponsored captive insurance company or an industrial insured captive insurance company, each as defined in section 38a-91aa of the general statutes, that has:

(A) Ceased transacting insurance business; and

(B) No liabilities associated with any insurance business that occurred, or insurance policy that was issued, prior to, on or after the filing of its application for a certificate of dormancy under subsection (b) of this section; and

(2) "Insurance business" means the business of insurance, as defined in section 38a-905 of the general statutes.

(b) A dormant captive insurance company that is domiciled in this state may apply to the Insurance Commissioner for a certificate of dormancy. The certificate of dormancy shall be subject to renewal once every two years, and shall be forfeited if the dormant captive insurance company commences transacting insurance business or fails to timely renew such certificate.

(c) A dormant captive insurance company that has been issued a certificate of dormancy shall:

(1) Possess and maintain unimpaired, paid-in capital and surplus of not less than twenty-five thousand dollars;

(2) Not later than March 15, 2018, annually, submit to the commissioner a report on the financial condition of such company, verified by oath of two executive officers of such company, in such form as the commissioner prescribes; and

(3) Pay the license renewal fee specified in section 38a-11 of the general statutes for a captive insurance company.

Sec. 2. Section 38a-91dd of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) (1) The Insurance Commissioner shall not issue a license to a captive insurance company or allow the company to retain such license unless the company has and maintains unimpaired paid-in capital and surplus of:

(A) In the case of a pure captive insurance company, not less than two hundred fifty thousand dollars;

(B) In the case of an association captive insurance company, not less than five hundred thousand dollars;

(C) In the case of an industrial insured captive insurance company, not less than five hundred thousand dollars;

(D) In the case of a risk retention group, not less than one million dollars;

(E) In the case of a sponsored captive insurance company, not less than **[**five hundred**]** two hundred twenty-five thousand dollars;

(F) In the case of a special purpose financial captive insurance company, not less than two hundred fifty thousand dollars; and

(G) In the case of a sponsored captive insurance company licensed as a special purpose financial captive insurance company, not less than five hundred thousand dollars.

(2) (A) The Insurance Commissioner shall not issue a license to a branch captive insurance company or allow the company to retain such license unless the company has and maintains, as security for the payment of liabilities attributable to the branch operations:

(i) Not less than two hundred fifty thousand dollars; and

(ii) Reserves on such insurance policies or such reinsurance contracts as may be issued or assumed by the branch captive insurance company through its branch operations, including reserves for losses, allocated loss adjustment expenses, incurred but not reported losses and unearned premiums with regard to business written through the branch operations. The commissioner may permit a branch captive insurance company to credit against any such reserves any security for loss reserves that the branch captive insurance company posts with a ceding insurer or is posted by a reinsurer with the branch captive insurance company, so long as such security remains posted.

(B) The amounts required under subparagraph (A) of this subdivision may be held, with the prior approval of the commissioner, in the form of (i) a trust formed under a trust agreement and funded by assets acceptable to the commissioner, (ii) an irrevocable letter of

credit issued or confirmed by a bank approved by the commissioner, (iii) with respect to the amount required under subparagraph (A)(i) of this subdivision only, cash on deposit with the commissioner, or (iv) any combination thereof.

(b) The commissioner may adopt regulations, in accordance with chapter 54, to establish additional capital and surplus requirements based upon the type, volume and nature of insurance business transacted.

(c) Notwithstanding any other provision of this section, the commissioner shall have the discretion to allow a captive insurance company, other than a captive insurance company organized as a risk retention group, to maintain less than the required unimpaired paid-in capital and surplus set forth in subsection (a) of this section. The commissioner shall consider the type, volume and nature of the insurance or reinsurance business transacted by such a captive insurance company in establishing the amount of unimpaired paid-in capital and surplus the company is required to maintain.

[(c)**]** (d) Except as specified in subdivision (2) of subsection (a) of this section, capital and surplus may be in the form of cash or an irrevocable letter of credit issued by a bank approved by the commissioner.

Sec. 3. Section 38a-91rr of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) Each sponsored captive insurance company may establish and maintain one or more protected cells, subject to the following conditions:

(1) The stockholders of a sponsored captive insurance company shall be limited to its participants and sponsors, except that a sponsored captive insurance company may issue nonvoting securities to other persons on terms approved by the commissioner;

(2) Each sponsored captive insurance company shall account separately on the books and records of such company for each protected cell to reflect the financial condition and results of operations of such protected cell, net income or loss, dividends or other distributions to participants and such other factors as may be provided in the participant contract or required by the commissioner;

(3) No liabilities arising out of any other insurance business the sponsored captive insurance company may conduct shall be chargeable against the assets of a protected cell;

(4) No sponsored captive insurance company shall make any sale, exchange or other transfer of assets, dividend or distribution between or among any of its protected cells without the consent of such protected cells;

(5) No protected cell shall make any sale, exchange or other transfer of assets, dividend or distribution to a sponsor or participant without the commissioner's approval. The commissioner shall not approve such sale, exchange or other transfer if it would result in insolvency or impairment with respect to a protected cell;

(6) (A) Except as otherwise specified, each sponsored captive insurance company shall attribute assets and liabilities to the protected cells and the general account in accordance with the plan of operation approved by the commissioner, and shall not attribute any other assets or liabilities between its general account and any protected cell or between any protected cells. For purposes of this subdivision, "general account" means all assets and liabilities of a sponsored captive insurance company that are not attributable to a protected cell.

(B) Each sponsored captive insurance company shall attribute all insurance obligations, assets and liabilities relating to a reinsurance contract entered into with respect to a protected cell to such protected cell. The performance under such reinsurance contract and any tax benefits, losses, refunds or credits allocated pursuant to a tax allocation agreement to which the sponsored captive insurance company is a

party, including any payments made by or due to be made to the sponsored captive insurance company pursuant to the terms of such agreement, shall reflect such obligations, assets and liabilities relating to such reinsurance contract;

[(7) In connection with the conservation, rehabilitation or liquidation of a sponsored captive insurance company, such company shall, to the extent the commissioner determines they are separable, keep the assets and liabilities of a protected cell separate at all times from, and shall not commingle with, those of other protected cells and of the sponsored captive insurance company;**]**

[(8)**]** (7) Each sponsored captive insurance company shall file annually with the commissioner such financial reports as the commissioner shall require, including, but not limited to, accounting statements detailing the financial experience of each protected cell;

[(9)**]** (8) Each sponsored captive insurance company shall notify the commissioner in writing not later than ten business days after any protected cell becomes insolvent or otherwise unable to meet its claim or expense obligations;

[(10)**]** (9) No participant contract shall take effect without the commissioner's prior written approval. The addition of each new protected cell or the withdrawal of any participant or termination of any existing protected cell shall constitute a change in the sponsored captive insurance company's plan of operation and shall require the commissioner's prior written approval;

[(11)**]** (10) If required by the commissioner, the business written by a sponsored captive insurance company with respect to each protected cell shall be (A) fronted by an insurance company licensed under the laws of any state, (B) reinsured by a reinsurer authorized or approved by this state, or (C) secured by a trust fund in the United States for the benefit of policyholders and claimants or funded by an irrevocable letter of credit or other arrangement that is acceptable to the commissioner. The commissioner may require the sponsored captive

insurance company to increase the funding of any security arrangement established under this subdivision. If the form of security is a letter of credit, the letter of credit shall be issued or confirmed by a bank approved by the commissioner. A trust maintained pursuant to this subdivision shall be established in a form and upon such terms approved by the commissioner.

(b) Each sponsored captive insurance company may combine the assets of two or more protected cells for purposes of investment and such combination shall not be construed as defeating the segregation of such assets for accounting or other purposes. Each sponsored captive insurance company shall comply with all applicable investment requirements under this chapter, except that the commissioner shall waive compliance with such requirements for sponsored captive insurance companies to the extent that credit for reinsurance ceded to reinsurers is allowed pursuant to section 38a-91kk. The commissioner may approve the use of alternative reliable methods of valuation and rating for purposes of this subsection.

(c) Each sponsored captive insurance company, including a sponsored captive insurance company licensed as a special purpose financial captive insurance company, may establish and maintain one or more protected cells as a separate corporation formed under chapter 601 or a limited liability company formed under chapter 613. This section shall not be construed to limit any rights or protections applicable to protected cells not established as corporations or limited liability companies.

(d) (1) Each sponsored captive insurance company may establish and maintain a protected cell as an incorporated protected cell.

(2) The articles of incorporation or articles of organization of an incorporated protected cell shall refer to the sponsored captive insurance company for which it is a protected cell and shall state that the protected cell is incorporated or organized for the limited purposes authorized by the sponsored captive insurance company's license.

Such company shall attach to and file with the articles of incorporation or articles of organization a copy of the commissioner's prior written approval, as required by subdivision **[**(10)**]** (9) of subsection (a) of this section, to add the incorporated protected cell.

(e) Notwithstanding the provisions of chapter 704c:

(1) If the commissioner determines in the event of an insolvency of a sponsored captive insurance company that one or more protected cells remain solvent, the commissioner may separate such cells from such company and may, on application of a sponsor, allow for the conversion of such cells into one or more new or existing sponsored captive insurance companies with a sponsor or sponsors, or one or more other captive insurance companies, pursuant to such plan or plans of operation as the commissioner deems acceptable;

(2) Upon the issuance by a court of any order of **[**supervision**]** conservation, rehabilitation or liquidation of a sponsored captive insurance company, the receiver shall manage the assets and liabilities of such company in accordance with the provisions of this section;

(3) The assets of a protected cell shall not be used to pay any expenses or claims other than those attributable to such protected cell; **[**and**]**

(4) A sponsored captive insurance company's capital and surplus shall be available at all times to pay any expenses of or claims against such company; **[**.**]**

(5) In connection with the conservation, rehabilitation or liquidation of a sponsored captive insurance company, the assets and liabilities of each protected cell shall at all times be kept separate from, and shall not be commingled with, the assets and liabilities of any other protected cell or the sponsored captive insurance company;

(6) Unless the sponsor consents and the commissioner has granted prior written approval, the assets of a sponsored captive insurance

company's general account shall not be used to pay any expense or claim attributable solely to one or more protected cells of the sponsored captive insurance company. If the assets of a sponsored captive insurance company's general account are used to pay expenses or claims attributable solely to one or more of the company's protected cells, the sponsor shall not be required to contribute additional capital and surplus to the company's general account. Notwithstanding any provision of this subdivision, the sponsor must satisfy the minimum capital and surplus requirements applicable to such sponsor in order to maintain its license; and

(7) A sponsored captive insurance company's capital and surplus shall at all times be available to pay any expense of, or claim against, the sponsored captive insurance company.

(f) Consistent with the provisions of this section, a creditor of a sponsored captive insurance company shall have recourse against any asset attributable to a protected cell if it is a creditor of the protected cell. A creditor of a protected cell shall not have any recourse against any asset attributable to another protected cell or in the sponsored captive insurance company's general account.

(g) When a sponsored captive insurance company has an obligation to a creditor arising from a transaction, or otherwise imposed, with respect to a particular protected cell, the obligation shall:

(1) Extend only to the assets attributable to the protected cell, and the creditor shall be entitled to recourse only against the assets attributable to such protected cell; and

(2) Not extend to any asset of another protected cell or in the sponsored captive insurance company's general account, and the creditor shall not be entitled to recourse against any asset attributable to another protected cell or in the company's general account.

(h) When an obligation of a sponsored captive insurance company relates solely to such company's general account, a creditor shall, with

respect to such obligation, be entitled to recourse only against the assets in such account.

(i) The establishment of one or more protected cells alone, without more, shall not, by itself, constitute (1) a fraudulent conveyance, (2) evidence of intent by a sponsored captive insurance company to defraud creditors, or (3) the conduct of business by a sponsored captive insurance company for any other fraudulent purpose.

Sec. 4. (NEW) (*Effective October 1, 2017*) (a) As used in this section, "short-term care policy" means any group health insurance policy or certificate delivered or issued for delivery to any resident of this state that is designed to provide, within the terms and conditions of the policy or certificate, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for a period not exceeding three hundred days. "Short-term care policy" does not include any such policy or certificate that is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(b) (1) No short-term care policy or certificate shall be delivered or issued for delivery to any resident in this state, nor shall any application, rider or endorsement be used in connection with such policy or certificate, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the Insurance Commissioner. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to establish a procedure for reviewing such policies and certificates. The commissioner shall disapprove the use of such form at any time if the form does not conform to the requirements of law, or if the form contains a provision or provisions that are unfair or deceptive or that

encourage misrepresentation of the policy or certificate. The commissioner shall notify, in writing, the insurer that has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy or certificate on or containing such form. The provisions of section 38a-19 of the general statutes shall apply to such orders.

(2) No rate filed under the provisions of subdivision (1) of this subsection shall be effective until it has been approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to prescribe standards to ensure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate if it fails to comply with such standards.

(c) (1) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any short-term care policy or certificate without providing, at the time of application or solicitation for purchase or sale of such coverage, full and fair written disclosure of the benefits and limitations of the policy or certificate.

(2) Each applicant for purchase of a short-term care policy or certificate shall sign an acknowledgment at the time of application for such policy or certificate that the company, society, corporation or center has provided the written disclosure required under this subsection to the applicant. If the method of application does not allow for such signature at the time of application, the applicant shall sign such acknowledgment not later than at the time of delivery of such policy or certificate.

(3) Except for a short-term care policy or certificate for which no applicable premium rate revision or rate schedule increases can be made, such disclosure shall include:

(A) A statement in not less than twelve-point bold face type that the policy or certificate does not provide long-term care insurance coverage and is not a long-term care insurance policy or certificate or a Connecticut Partnership for Long-Term Care insurance policy or certificate;

(B) A statement that the policy or certificate may be subject to rate increases in the future;

(C) An explanation of potential future premium rate revisions and the policyholder's or certificate holder's option in the event of a premium rate revision; and

(D) The premium rate or rate schedule applicable to the applicant for purchase of the short-term care policy or certificate that will be in effect until such company, society, corporation or center files a request with the commissioner for a revision to such premium rate or rate schedule.

(d) (1) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any short-term care policy or certificate in this state shall refuse to accept, or refuse to make reimbursement pursuant to, a claim for benefits submitted by or prepared with the assistance of a managed residential community, as defined in section 19a-693 of the general statutes, in accordance with subdivision (7) of subsection (a) of section 19a-694 of the general statutes, solely because such claim for benefits was submitted by or prepared with the assistance of a managed residential community.

(2) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any short-term care policy or certificate in this state shall, upon receipt of a written authorization executed by the insured, (A) disclose information to a managed residential community for the purpose of

determining such insured's eligibility for an insurance benefit or payment, and (B) provide a copy of the initial acceptance or declination of a claim for benefits to the managed residential community at the same time such acceptance or declination is made to the insured.

(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section. Such regulations shall include, but need not be limited to, (1) the permissible loss ratio for a short-term care policy or certificate, if any, (2) the permissible exclusionary periods for coverage under a short-term care policy or certificate, if any, (3) the circumstances under which a short-term care policy or certificate will be renewable, and (4) the benefits payable under a short-term care policy or certificate in relation to other insurance coverage that provides benefits to the insured.

Sec. 5. Section 38a-177 of the general statutes, as amended by section 22 of public act 16-213, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

A health care center may provide health care (1) directly or by its employees or contractors licensed by this state to render such services, or by contract or by indemnity arrangement with any hospital, hospital service corporation, medical service corporation or person qualified and licensed to render any health care service or by both methods; **[**and**]** or (2) by other methods to the extent permitted under the Federal Health Maintenance Organization Act and the regulations adopted thereunder from time to time unless otherwise determined by the commissioner **[**by regulation**]** in regulations adopted in accordance with the provisions of chapter 54. A health care center may also enter into agreements with hospitals or individuals approved by their respective state regulating board, licensed to practice any of the healing arts, for the training of personnel under the direction of persons licensed to practice the profession or healing art. A health care center may also maintain a clinic or clinics for the prevention, study,

diagnosis and treatment of human ailments and injuries by licensed persons and to promote medical, surgical, dental or scientific research and learning.

Sec. 6. Section 38a-323 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) (1) No insurer shall refuse to renew any policy **[**which**]** that is subject to the requirements of sections 38a-663 to 38a-696, inclusive, unless such insurer or its agent sends, by registered or certified mail or by mail evidenced by a certificate of mailing, or delivers to the named insured, at the address shown in the policy, at least sixty days' advance notice of its intention not to renew. The notice of intent not to renew shall state or be accompanied by a statement specifying the reason for such nonrenewal. This section shall not apply: **[**(1)**]** (A) In case of nonpayment of premium; **[**(2)**]** (B) if the insured fails to pay any advance premium required by the insurer for renewal, provided, notwithstanding the failure of an insurer to comply with this subsection, with respect to automobile liability insurance policies the policy shall terminate on the effective date of any other insurance policy with respect to any automobile designated in both policies; or **[**(3)**]** (C) if the policy is transferred from the insurer to an affiliate of such insurer for another policy with no interruption of coverage and contains the same terms, conditions and provisions, including policy limits, as the transferred policy, except that the insurer to which the policy is transferred shall not be prohibited from applying its rates and rating plans at the time of renewal. With respect to an automobile or homeowners policy, each insurer that sends or delivers a notice of nonrenewal pursuant to this subsection shall use the same method to send or deliver such notice to any third party designated pursuant to section 38a-323a.

(2) If an insurer intends to renew any policy that is subject to the requirements of sections 38a-663 to 38a-696, inclusive, under terms or conditions less favorable to the insured than provided under the existing policy, the insurer shall send a conditional renewal notice in

the manner required for a notice of nonrenewal under subdivision (1) of this subsection. The conditional renewal notice shall clearly state or be accompanied by a statement clearly identifying any reduction in coverage limits, coverage provisions added or revised that reduce coverage or increases in deductibles, under the renewal policy.

(b) (1) **[**On or before September 30, 1987, a**]** A premium billing notice for any policy subject to the requirements of sections 38a-663 to 38a-696, inclusive, except a workers' compensation policy, shall be mailed or delivered to the insured by the insurer or its agent not less than **[**forty-five days in advance of the renewal date or the anniversary date of the policy. On or after October 1, 1987, such notice shall be so mailed or delivered to the insured not less than**]** thirty days in advance of the policy's renewal or anniversary date, except that **[**on or after October 1, 1998,**]** such notice shall not be required for a commercial risk policy if the premium for the ensuing policy period is to increase less than ten per cent on an annual basis. The premium billing notice shall be based on the rates and rules applicable to the ensuing policy period and shall include a notice of transfer when the policy has been transferred from an insurer to an affiliate of such insurer pursuant to the provisions of **[**subdivision (3)**]** subparagraph (C) of subdivision (1) of subsection (a) of this section. The provisions of this subsection shall apply to any such policy for which the annual premium was less than fifty thousand dollars for the preceding annual policy period.

(2) For purposes of any commercial risk policy subject to the requirements of sections 38a-663 to 38a-696, inclusive, except a workers' compensation policy, the mailing or delivery of a premium billing notice by an insurer's managing general agent, in accordance with the provisions of subdivision (1) of this subsection, shall constitute compliance by such insurer with said subdivision.

(c) Failure of the insurer or its agent to provide the insured with the required notice of nonrenewal or premium billing shall entitle the insured to: (1) Renewal of the policy for a term of not less than one year, and (2) the privilege of pro-rata cancellation at the lower of the

current or previous year rates if exercised by the insured within sixty days from the renewal date or anniversary date. Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation **[**which**]** that existed before the effective date of such renewal.

(d) Notwithstanding the provisions of subsection (b) of this section, the advance notice period for any premium billing notice shall be at least sixty days for any liability insurance policy wherein a municipality is the named insured.

(e) Notwithstanding the provisions of subdivision (1) of subsection (a) of this section, the advance notice period for any refusal to renew any professional liability policy shall be at least ninety days.

(f) (1) No surplus lines insurer shall be deemed eligible to write coverage for risks as provided in sections 38a-741 to 38a-744, inclusive, and 38a-794, unless such surplus lines insurer complies with the requirements of this section.

(2) Notwithstanding the provisions of subsection (b) of this section, premium billing notices shall be provided by any surplus lines insurer to the insured at least sixty days in advance of the renewal or anniversary date of the policy. Notices of nonrenewal or premium billing required by this section shall be provided by the surplus lines insurer or its duly authorized representative to the insured.

(3) Notwithstanding the provisions of subsection (c) of this section, failure of any surplus lines insurer to provide the insured with the required notice of nonrenewal or premium billing shall entitle the insured to an extension of the policy for a period of ninety days after the renewal or anniversary date of such policy, **[**provided**]** except that if the surplus lines insurer fails to provide the required notice on or before the renewal or anniversary date of such policy, the provisions of subsection (c) of this section shall apply. In the event of such a ninety-day extension of coverage, the premium for the extended period of coverage shall be the current rate or the previous rate, whichever is

lower.

(g) For purposes of any market conduct examination performed pursuant to section 38a-15, the Insurance Commissioner may find an insurer to be in compliance with the requirements of this section upon a determination that such insurer made a good faith effort to so comply.

Sec. 7. Subsection (a) of section 38a-930 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) (1) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation under sections 38a-903 to 38a-961, inclusive, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then such transfers shall be deemed preferences if made or suffered within one year before the filing of the successful petition for rehabilitation, or within two years before the filing of the successful petition for liquidation, whichever time is shorter.

(2) Any preference may be avoided by the liquidator if: (A) The insurer was insolvent at the time of the transfer; (B) the transfer was made within four months before the filing of the petition; (C) the creditor receiving it or to be benefited thereby or **[**his**]** such creditor's agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or (D) the creditor receiving it was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not **[**he**]** such employee, attorney or other person held such position, or any shareholder holding directly or indirectly more than

five per [centum] cent of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(3) Where the preference is voidable, the liquidator may recover the property, or if it has been converted, its value from any person who has received or converted the property, except where a bona fide purchaser or lienor has given less than fair equivalent value, [he] such purchaser or lienor shall have a lien upon the property to the extent of the consideration actually given by [him] such purchaser or lienor. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

(4) Notwithstanding subdivisions (1) to (3), inclusive, of this subsection, a transfer pursuant to a commutation of a reinsurance agreement that is approved by the commissioner or the commissioner's designated appointee under section 38a-962d shall not be voidable as a preference. For the purposes of this subdivision, a commutation of a reinsurance agreement is the elimination of all present and future obligations between the parties, arising from the reinsurance agreement, in exchange for a current consideration.

Sec. 8. Subsection (b) of section 38a-140 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(b) Whenever it appears to the commissioner that any person has committed a violation of sections 38a-129 to 38a-140, inclusive, as amended by this act, that so impairs the financial condition of a domestic insurance company as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, securityholders or the public, the commissioner may proceed as provided in [section 38a-18] chapter 704c to take possession of the

property of such domestic insurance company and to conduct the business thereof.

Sec. 9. Subsection (d) of section 38a-395 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(d) (1) The commissioner shall establish an electronic database composed of closed claim reports filed pursuant to this section.

(2) The commissioner shall compile the data included in individual closed claim reports into an aggregated summary format and shall prepare a written annual report of the summary data. The report shall provide an analysis of closed claim information including a minimum of five years of comparative data, when available, trends in frequency and severity of claims, itemization of damages, timeliness of the claims process, and any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

(3) The annual report shall include a summary of rate filings for professional liability insurance for medical professionals or hospitals, which have been approved by the department for the prior calendar year, including an analysis of the trend of direct losses, incurred losses, earned premiums and investment income as compared to prior years. The report shall include base premiums charged by insurers for each specialty and the number of providers insured by specialty for each insurer.

(4) Not later than **[**March 15, 2007**]** June 30, 2018, and annually thereafter, the commissioner shall submit the annual report to the joint standing committee of the General Assembly having cognizance of matters relating to insurance in accordance with section 11-4a. The commissioner shall also (A) make the report available to the public, (B) post the report on its Internet site, and (C) provide public access to the contents of the electronic database after the commissioner establishes that the names and other individually identifiable information about the claimant and practitioner have been removed.

Sec. 10. Section 38a-479aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) As used in this part and subsection (b) of section 20-138b:

(1) "Covered benefits" means health care services to which an enrollee is entitled under the terms of a managed care plan;

(2) "Enrollee" means an individual who is eligible to receive health care services through a preferred provider network;

(3) "Health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization, and includes hospital, medical, surgical, dental, vision and pharmaceutical services or products;

(4) "Managed care organization" means (A) a managed care organization, as defined in section 38a-478, (B) any other health insurer, or (C) a reinsurer with respect to health insurance;

(5) "Managed care plan" **[**means a managed care plan, as defined**]** has the same meaning as provided in section 38a-478;

(6) "Person" means an individual, agency, political subdivision, partnership, corporation, limited liability company, association or any other entity;

(7) "Preferred provider network" means a person **[**, which**]** that is not a managed care organization, but **[**which**]** that pays claims for the delivery of health care services, accepts financial risk for the delivery of health care services and establishes, operates or maintains an arrangement or contract with providers relating to (A) the health care services rendered by the providers, and (B) the amounts to be paid to the providers for such services. "Preferred provider network" does not include (i) a workers' compensation preferred provider organization established pursuant to section 31-279-10 of the regulations of Connecticut state agencies, (ii) an independent practice association or

physician hospital organization whose primary function is to contract with insurers and provide services to providers, (iii) a clinical laboratory, licensed pursuant to section 19a-30, whose primary payments for any contracted or referred services are made to other licensed clinical laboratories or for associated pathology services, or (iv) a pharmacy benefits manager responsible for administering pharmacy claims whose primary function is to administer the pharmacy benefit on behalf of a health benefit plan;

(8) "Provider" means an individual or entity duly licensed or legally authorized to provide health care services; and

(9) "Commissioner" means the Insurance Commissioner.

(b) **[**On and after May 1, 2004, no**]** No preferred provider network may enter into or renew a contractual relationship with a managed care organization or conduct business in this state unless the preferred provider network is licensed by the commissioner. **[**On and after May 1, 2005, no preferred provider network may conduct business in this state unless it is licensed by the commissioner.**]** Any person seeking to obtain or renew a license shall submit an application to the commissioner, on such form as the commissioner may prescribe, and shall include the filing described in this subsection, except that a person seeking to renew a license may submit only the information necessary to update its previous filing. **[**Applications**]** Such license shall be issued or renewed annually on July first and applications shall be submitted by **[**March**]** May first of each year in order to qualify for the **[**May first**]** license issue or renewal date. The filing required from such preferred provider network shall include the following information: (1) The identity of the preferred provider network and any company or organization controlling the operation of the preferred provider network, including the name, business address, contact person, a description of the controlling company or organization and, where applicable, the following: (A) A certificate from the Secretary of the State regarding the preferred provider network's and the controlling company's or organization's good standing to do business

in the state; (B) a copy of the preferred provider network's and the controlling company's or organization's financial statement completed in accordance with sections 38a-53 and 38a-54, as applicable, for the end of its most recently concluded fiscal year, along with the name and address of any public accounting firm or internal accountant which prepared or assisted in the preparation of such financial statement; (C) a list of the names, official positions and occupations of members of the preferred provider network's and the controlling company's or organization's board of directors or other policy-making body and of those executive officers who are responsible for the preferred provider network's and controlling company's or organization's activities with respect to the health care services network; (D) a list of the preferred provider network's and the controlling company's or organization's principal owners; (E) in the case of an out-of-state preferred provider network, controlling company or organization, a certificate that such preferred provider network, company or organization is in good standing in its state of organization; (F) in the case of a Connecticut or out-of-state preferred provider network, controlling company or organization, a report of the details of any suspension, sanction or other disciplinary action relating to such preferred provider network, or controlling company or organization in this state or in any other state; and (G) the identity, address and current relationship of any related or predecessor controlling company or organization. For purposes of this subparagraph, "related" means that a substantial number of the board or policy-making body members, executive officers or principal owners of both companies are the same; (2) a general description of the preferred provider network and participation in the preferred provider network, including: (A) The geographical service area of and the names of the hospitals included in the preferred provider network; (B) the primary care physicians, the specialty physicians, any other contracting providers and the number and percentage of each group's capacity to accept new patients; (C) a list of all entities on whose behalf the preferred provider network has contracts or agreements to provide health care services; (D) a table listing all major categories of health care services provided by the

preferred provider network; (E) an approximate number of total enrollees served in all of the preferred provider network's contracts or agreements; (F) a list of subcontractors of the preferred provider network, not including individual participating providers, that assume financial risk from the preferred provider network and to what extent each subcontractor assumes financial risk; (G) a contingency plan describing how contracted health care services will be provided in the event of insolvency; and (H) any other information requested by the commissioner; and (3) the name and address of the person to whom applications may be made for participation.

(c) Any person developing a preferred provider network, or expanding a preferred provider network into a new county, pursuant to this section and subsection (b) of section 20-138b, shall publish a notice, in at least one newspaper having a substantial circulation in the service area in which the preferred provider network operates or will operate, indicating such planned development or expansion. Such notice shall include the medical specialties included in the preferred provider network, the name and address of the person to whom applications may be made for participation and a time frame for making application. The preferred provider network shall provide the applicant with written acknowledgment of receipt of the application. Each complete application shall be considered by the preferred provider network in a timely manner.

(d) (1) Each preferred provider network shall file with the commissioner and make available upon request from a provider the general criteria for its selection or termination of providers. Disclosure shall not be required of criteria deemed by the preferred provider network to be of a proprietary or competitive nature that would hurt the preferred provider network's ability to compete or to manage health care services. For purposes of this section, criteria is of a proprietary or competitive nature if it has the tendency to cause providers to alter their practice pattern in a manner that would circumvent efforts to contain health care costs and criteria is of a proprietary nature if revealing the criteria would cause the preferred

provider network's competitors to obtain valuable business information.

(2) If a preferred provider network uses criteria that have not been filed pursuant to subdivision (1) of this subsection to judge the quality and cost-effectiveness of a provider's practice under any specific program within the preferred provider network, the preferred provider network may not reject or terminate the provider participating in that program based upon such criteria until the provider has been informed of the criteria that the provider's practice fails to meet.

(e) Each preferred provider network shall permit the Insurance Commissioner to inspect its books and records.

(f) Each preferred provider network shall permit the commissioner to examine, under oath, any officer or agent of the preferred provider network or controlling company or organization with respect to the use of the funds of the preferred provider network, company or organization, and compliance with (1) the provisions of this part, and (2) the terms and conditions of its contracts to provide health care services.

(g) Each preferred provider network shall file with the commissioner a notice of any material modification of any matter or document furnished pursuant to this part, and shall include such supporting documents as are necessary to explain the modification.

(h) Each preferred provider network shall maintain a minimum net worth of either (1) the greater of (A) **[**two hundred fifty thousand**]** five hundred thousand dollars, or (B) an amount equal to eight per cent of its annual expenditures as reported on its most recent financial statement completed and filed with the commissioner in accordance with sections 38a-53 and 38a-54, as applicable, or (2) another amount determined by the commissioner.

(i) Each preferred provider network shall maintain or arrange for a

letter of credit, bond, surety, reinsurance, reserve or other financial security acceptable to the commissioner for the exclusive use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment except that any remaining security may be used for the purpose of reimbursing managed care organizations in accordance with subsection (b) of section 38a-479bb. Such outstanding amount shall be at least an amount equal to the greater of (1) an amount sufficient to make payments to participating providers for **[**two**]** four months determined on the basis of the **[**two**]** four months within the past year with the greatest amounts owed by the preferred provider network to participating providers, (2) the actual outstanding amount owed by the preferred provider network to participating providers, or (3) another amount determined by the commissioner. Such amount may be credited against the preferred provider network's minimum net worth requirements set forth in subsection (h) of this section. The commissioner shall review such security amount and calculation on a quarterly basis.

(j) Each preferred provider network shall pay the applicable license or renewal fee specified in section 38a-11. The commissioner shall use the amount of such fees solely for the purpose of regulating preferred provider networks.

(k) In no event, including, but not limited to, nonpayment by the managed care organization, insolvency of the managed care organization, or breach of contract between the managed care organization and the preferred provider network, shall a preferred provider network bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or an enrollee's designee, other than the managed care organization, for covered benefits provided, except that the preferred provider network may collect any copayments, deductibles or other out-of-pocket expenses that the enrollee is required to pay pursuant to the managed care plan.

(l) Each contract or agreement between a preferred provider

network and a participating provider shall contain a provision that if the preferred provider network fails to pay for health care services as set forth in the contract, the enrollee shall not be liable to the participating provider for any sums owed by the preferred provider network or any sums owed by the managed care organization because of nonpayment by the managed care organization, insolvency of the managed care organization or breach of contract between the managed care organization and the preferred provider network.

(m) Each utilization review determination made by or on behalf of a preferred provider network shall be made in accordance with section 38a-591d.

(n) The requirements of subsections (h) and (i) of this section shall not apply to a consortium of federally qualified health centers funded by the state, providing services only to recipients of programs administered by the Department of Social Services. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to establish criteria to certify any such federally qualified health center, including, but not limited to, minimum reserve fund requirements.

Sec. 11. Subdivision (8) of section 9-601 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(8) "Business entity" means the following, whether organized in or outside of this state: Stock corporations, banks, insurance companies, business associations, bankers associations, insurance associations, trade or professional associations which receive funds from membership dues and other sources, partnerships, joint ventures, private foundations, as defined in Section 509 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended; trusts or estates; corporations organized under sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, 38a-199 to 38a-209, inclusive, and

38a-214 to 38a-225, inclusive, and chapters 594 to 597, inclusive; cooperatives, and any other association, organization or entity which is engaged in the operation of a business or profit-making activity; but does not include professional service corporations organized under chapter 594a and owned by a single individual, nonstock corporations which are not engaged in business or profit-making activity, organizations, as defined in subdivision (7) of this section, candidate committees, party committees and political committees as defined in this section. For purposes of this chapter, corporations which are component members of a controlled group of corporations, as those terms are defined in Section 1563 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, shall be deemed to be one corporation.

Sec. 12. Subsection (g) of section 10a-178 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(g) "Health care institution" means (1) any nonprofit, state-aided hospital or other health care institution, including The University of Connecticut Health Center, which is entitled, under the laws of the state, to receive assistance from the state by means of a grant made pursuant to a budgetary appropriation made by the General Assembly, (2) any other hospital or other health care institution which is licensed, or any nonprofit, nonstock corporation which shall receive financing or shall undertake to construct or acquire a project which is or will be eligible to be licensed, as an institution under the provisions of sections 19a-490 to 19a-503, inclusive, or any nonprofit, nonstock, nonsectarian facility which is exempt from taxation under the provisions of section 12-81 or 38a-188, as amended by this act, and which is a health care center under the provisions of sections 38a-175 to **[**38a-191**]** 38a-194, inclusive, as amended by this act, or (3) any nonprofit corporation wholly owned by two or more hospitals or other health care institutions which operates for and on behalf of such hospitals or other health care institutions a project, as defined in

subsection (b) of this section, or is a nursing home;

Sec. 13. Subsection (a) of section 12-202a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) Each health care center, as defined in section 38a-175, as amended by this act, that is governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, shall pay a tax to the Commissioner of Revenue Services for the calendar year commencing on January 1, 1995, and annually thereafter, at the rate of one and three-quarters per cent of the total net direct subscriber charges received by such health care center during each such calendar year on any new or renewal contract or policy approved by the Insurance Commissioner under section 38a-183, as amended by this act. Such payment shall be in addition to any other payment required under section 38a-48.

Sec. 14. Subparagraph (G) of subdivision (1) of subsection (a) of section 38a-71 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(G) Tangible components of health care delivery systems for health care centers governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, with the cost of these assets having a finite useful life being depreciated in full over periods provided by regulations adopted by the commissioner in accordance with the provisions of chapter 54;

Sec. 15. Subdivision (9) of section 38a-175 of the general statutes, as amended by section 20 of public act 16-213, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(9) "Health care center" means (A) any organization governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, and licensed or authorized by the commissioner pursuant to section 38a-41 or 38a-41a, for the purpose of carrying out the activities and

purposes set forth in subsection (b) of section 38a-176, as amended by this act, at the expense of the health care center, including the providing of health care to members of the community, including subscribers to one or more plans under an agreement entitling such subscribers to health care in consideration of a basic advance or periodic charge and shall include a health maintenance organization, or (B) a line of business conducted by an organization that is formed pursuant to the laws of this state for the purposes of, but not limited to, carrying out the activities and purposes set forth in subsection (b) of section 38a-176, as amended by this act.

Sec. 16. Subdivision (2) of subsection (b) of section 38a-176 of the general statutes, as amended by section 21 of public act 16-213, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(2) For a health care center that provides medical and surgical services other than or in addition to dental services, the nature of the activities to be conducted and the purposes to be carried out by such health care center, in addition to those set forth in subdivision (1) of this subsection, include, but are not limited to: (A) Entering into agreements with any governmental agency, or any provider for the training of personnel under the direction of persons licensed to practice any healing art; (B) establishing, operating and maintaining a medical service center, clinic or any such other facility as shall be necessary for the prevention, study, diagnosis and treatment of human ailments and injuries and to promote medical, surgical, dental and general health education, scientific education, research and learning; (C) marketing, enrolling and administering a health care plan; (D) contracting with insurers licensed in this state, including hospital service corporations and medical service corporations; (E) offering, in addition to health services, benefits covering out-of-area or emergency services; (F) providing health services not included in the health care plan on a fee-for-service basis; and (G) entering into contracts in furtherance of the purposes of sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act.

Sec. 17. Section 38a-178 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

Persons desiring to form a health care center may organize under the general law of the state governing corporations, partnerships, associations or trusts, subject to the following provisions: (1) The certificate of incorporation or other organizational document of each such organization shall have endorsed thereon or attached thereto the consent of the commissioner if the commissioner finds the same to be in accordance with the provisions of sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act; and (2) the certificate or other document shall include a statement of the area in which the health care center will operate and the services to be rendered by such organization within this state and in other jurisdictions in which the health care center may be authorized to do business.

Sec. 18. Subsection (a) of section 38a-179 of the general statutes, as amended by section 23 of public act 16-213, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) If a domestic health care center is organized as a nonprofit, nonstock corporation, the care, control and disposition of the property and funds of each such corporation and the general management of its affairs shall be vested in a board of directors. Each such corporation shall have the power to adopt bylaws for the governing of its affairs, which bylaws shall prescribe the number of directors, their term of office and the manner of their election, subject to the provisions of sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act. The bylaws may be adopted and repealed or amended by the affirmative vote of two-thirds of all the directors at any meeting of the board of directors duly held upon at least ten days' notice, provided notice of such meeting shall specify the proposed action concerning the bylaws to be taken at such meeting. The bylaws of the corporation shall provide that the board of directors shall include representation from persons engaged in the healing arts and from persons who are eligible to receive health care from the corporation, subject to the

following provisions: (1) One-quarter of the board of directors shall be persons engaged in the different fields in the healing arts at least two of whom shall be a physician and a dentist, except for a health care center that provides only dental services, one-quarter of the board of directors shall be persons engaged in the dental or related fields; and (2) one-quarter of the board of directors shall be subscribers who are eligible to receive health care from the health care center, but no such representative need be seated until the first annual meeting following the approval by the commissioner of the initial agreement or agreements to be offered by the corporation, and there shall be only one representative from any group covered by a group service agreement.

Sec. 19. Subsections (a) and (b) of section 38a-180 of the general statutes, as amended by section 24 of public act 16-213, are repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) Any clinic established under sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, including a clinic that is a part of a medical service center or other facility, shall be subject to approval as a clinic by the Commissioner of Public Health pursuant to the standards established by said commissioner for approved clinics.

(b) Any person licensed to practice any of the healing arts or occupations employed by a health care center governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, shall not be subject to reprimand or discipline because such person is an employee of the health care center or because such health care center may be engaged in rendering health care or related care through its own employees, except such person shall otherwise remain subject to reprimand or discipline by the state regulating board governing such profession or occupation as provided by law for such person's act or acts for unlawful, unprofessional or immoral conduct.

Sec. 20. Section 38a-181 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

A health care center governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, may accept from governmental agencies, or from private agencies, corporations, associations, groups or individuals, payments, grants, loans or anything of value concerning all or part of the cost of its operation or agreements entered into between such health care center and its subscribers or other persons to be served by the health care center, or its employees, suppliers or contractors.

Sec. 21. Subsection (a) of section 38a-182 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) An agreement issued by a health care center governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, may be issued for health care or the costs thereof to a subscriber, to a subscriber and spouse, to a subscriber and family, to a subscriber and dependent or dependents related by blood, marriage or adoption or to a subscriber and ward. Such agreement or evidence of coverage document shall be in writing and a copy thereof furnished to the group contract holder or individual contract holder, as appropriate.

Sec. 22. Subdivision (1) of subsection (a) of section 38a-183 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) (1) A health care center governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, shall not enter into any agreement with subscribers unless and until it has filed with the commissioner a full schedule of the amounts to be paid by the subscribers and has obtained the commissioner's approval thereof. Such filing shall include an actuarial memorandum that includes, but is not limited to, pricing assumptions and claims experience, and premium rates and loss ratios from the inception of the contract or policy. The commissioner may refuse such approval if the commissioner finds such amounts to be excessive, inadequate or

discriminatory. As used in this subsection, "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

Sec. 23. Section 38a-184 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

Each health care center governed by sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act, may expend sums, including sums in the capital reserve fund as provided in subsection (c) of section 38a-183, as amended by this act, for the following objects and purposes: (1) To purchase or lease real property for the purpose of construction of a medical service facility or center, an office building, or other facility useful or necessary in the implementation of its program; (2) to purchase, lease or renovate all or part of an existing medical service facility or center, an office building, or other facility useful or necessary in the implementation of its program or to lease a part of an existing hospital; (3) to amortize capital costs for the purchase, construction or renovation of a medical service facility or center, an office building, or other facility useful or necessary in the implementation of its program; (4) to purchase or lease equipment and such property as may be required in the delivery of health care and the transaction of business of the health care center; (5) to construct facilities, including a medical service facility or center, an office building, or other facility useful or necessary in the implementation of its program, and to alter, improve or enlarge such facilities; (6) to make loans, including loans to a corporation under its control, for any of the objects and purposes heretofore prescribed; (7) to do any or all of the foregoing jointly or in association with another health care center, or jointly or in association with any other person, including any other corporation affiliated with a health care center.

Sec. 24. Section 38a-185 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

From any order or decision of the commissioner relating to any

health care center governed by sections 38a-175 to [38a-192] 38a-194, inclusive, as amended by this act, an appeal may be taken by any person or organization aggrieved thereby in accordance with the provisions of section 4-183, except venue for such appeal shall be in the judicial district of New Britain. Any dispute which arises between a member of the community including subscribers eligible to receive health care from the health care center and each such center shall be referred, at the request of either party to such dispute, to the commissioner, who shall have the power to hear and decide the same, subject to appeal as herein provided.

Sec. 25. Section 38a-187 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

A health care center governed by sections 38a-175 to [38a-192] 38a-194, inclusive, as amended by this act, may purchase, lease, construct, renovate, operate and maintain medical facilities and equipment ancillary to such facilities and such other property as may be reasonably required for its principal office and for such purposes as may be necessary in the transaction of the business of the health care center, and may otherwise invest in other securities permitted by the general statutes for the investment of trust funds, and in such other securities alone.

Sec. 26. Section 38a-188 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) Each health care center governed by sections 38a-175 to [38a-192] 38a-194, inclusive, as amended by this act, shall be exempt from the provisions of the general statutes relating to insurance in the conduct of its operations under said sections and in such other activities as do constitute the business of insurance, unless expressly included therein, and except for the following: Sections 38a-11, 38a-14a, 38a-17, 38a-51, 38a-52, 38a-56, 38a-57, 38a-58a, 38a-129 to 38a-140, inclusive, as amended by this act, 38a-147 and 38a-815 to 38a-819, inclusive, provided a health care center shall not be deemed in violation of

sections 38a-815 to 38a-819, inclusive, solely by virtue of such health care center selectively contracting with certain providers in one or more specialties, and sections 38a-80, 38a-492b, 38a-518b, 38a-543, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, 38a-769, 38a-770, 38a-772 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794, provided a health care center organized as a nonprofit, nonstock corporation shall be exempt from sections 38a-146, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, 38a-769, 38a-770, 38a-772 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794. If a health care center is operated as a line of business, the foregoing provisions shall, where possible, be applied only to that line of business and not to the organization as a whole.

(b) The commissioner may adopt regulations, in accordance with chapter 54, stating the circumstances under which the resources of a person that controls a health care center, or operates a health care center as a line of business will be considered in evaluating the financial condition of a health care center. Such regulations, if adopted, shall require as a condition to the consideration of the resources of such person that controls a health care center, or operates a health care center as a line of business to provide satisfactory assurances to the commissioner that such person will assume the financial obligations of the health care center. During the period prior to the effective date of regulations issued under this section, the commissioner shall, upon request, consider the resources of a person that controls a health care center, or operates a health care center as a line of business, if the commissioner receives satisfactory assurances from such person that it will assume the financial obligations of the health care center and determines that such person meets such other requirements as the commissioner determines are necessary.

(c) A health care center organized as a nonprofit, nonstock corporation shall be exempt from the sales and use tax and all property of each such corporation shall be exempt from state, district and municipal taxes. Each corporation governed by sections 38a-175 to

[38a-192] 38a-194, inclusive, as amended by this act, shall be subject to the provisions of sections 38a-903 to 38a-961, inclusive. Nothing in this section shall be construed to override contractual and delivery system arrangements governing a health care center's provider relationships.

Sec. 27. Section 38a-189 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

No provision of sections 38a-175 to [38a-192] 38a-194, inclusive, as amended by this act, nor any contract for health care by a health care center governed by said sections shall, in any way, affect the operation of the Workers' Compensation Act.

Sec. 28. Section 38a-190 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

Any provisions of the statutes of this state regulating group medical, dental or other professions or occupations dealing with health care which is in conflict with sections 38a-175 to [38a-192] 38a-194, inclusive, as amended by this act, shall not apply to a health care center governed by said sections.

Sec. 29. Section 38a-191 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

Nothing in sections 38a-175 to [38a-192] 38a-194, inclusive, as amended by this act, shall preclude an insurance company authorized to conduct an accident and health insurance business in this state from performing marketing, enrollment, administration and other functions and from providing hospitalization insurance, including but not limited to emergency and out-of-area benefits, in conjunction with a plan providing health care to subscribers under existing provisions of the general statutes.

Sec. 30. Section 38a-192 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

The commissioner may adopt such regulations, in accordance with

the provisions of chapter 54, as shall be necessary to carry out the provisions of sections 38a-175 to **[**38a-192**]** 38a-194, inclusive, as amended by this act.

Sec. 31. Subdivision (6) of subsection (a) of section 38a-472f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(6) (A) "Health benefit plan" **[**has the same meaning as provided in section 38a-591a;**]** means an insurance policy or contract, certificate or agreement offered, delivered, issued for delivery, renewed, amended or continued in this state to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services;

(B) "Health benefit plan" does not include:

(i) Coverage of the type specified in subdivisions (5) to (9), inclusive, (14) and (15) of section 38a-469 or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

(vii) Coverage for on-site medical clinics;

(viii) Other insurance coverage similar to the coverages specified in subparagraphs (B)(ii) to (B)(vii), inclusive, of this subdivision that are specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, under which benefits for health care services are secondary or incidental to other insurance benefits;

(ix) (I) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof, or (II) other similar, limited benefits that are specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, provided any benefits specified in subparagraphs (B)(ix)(I) and (B)(ix)(II) of this subdivision are provided under a separate insurance policy, certificate or contract and are not otherwise an integral part of a health benefit plan; or

(x) Coverage of the type specified in subdivisions (3) and (13) of section 38a-469 or other fixed indemnity insurance if (I) such coverage is provided under a separate insurance policy, certificate or contract, (II) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (III) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor;

Sec. 32. Section 19a-7p of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to any public health fee due on or after February 1, 2017*):

(a) Not later than September first, annually, the Secretary of the Office of Policy and Management, in consultation with the Commissioner of Public Health, shall (1) determine the amounts appropriated for the needle and syringe exchange program, AIDS services, breast and cervical cancer detection and treatment, x-ray screening and tuberculosis care, and venereal disease control; and (2) inform the Insurance Commissioner of such amounts.

(b) (1) As used in this section: (A) "Health insurance" means health insurance of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469; and (B) "health care center" has the same meaning as provided in section 38a-175, as amended by this act.

(2) Each domestic insurer or domestic health care center doing

health insurance business in this state shall annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under section 38a-52a, a public health fee assessed by the Insurance Commissioner pursuant to this section.

(3) Not later than September first, annually, each such insurer or health care center shall report to the Insurance Commissioner, in the form and manner prescribed by said commissioner, the number of insured or enrolled lives in this state as of May first immediately preceding the date for which such insurer or health care center is providing health insurance that provides coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469. Such number shall not include lives enrolled in Medicare, any medical assistance program administered by the Department of Social Services, workers' compensation insurance or Medicare Part C plans.

(c) Not later than November first, annually, the Insurance Commissioner shall determine the fee to be assessed for the current fiscal year against each such insurer and health care center. Such fee shall be calculated by multiplying the number of lives reported to said commissioner pursuant to subdivision (3) of subsection (b) of this section by a factor, determined annually by said commissioner as set forth in this subsection, to fully fund the aggregate amount determined under subsection (a) of this section. The Insurance Commissioner shall determine the factor by dividing the aggregate amount by the total number of lives reported to said commissioner pursuant to subdivision (3) of subsection (b) of this section.

(d) Not later than December first, annually, the Insurance Commissioner shall submit a statement to each such insurer and health care center that includes the proposed fee, identified on such statement as the "Public Health fee", for the insurer or health care center, calculated in accordance with this section. Not later than December twentieth, annually, any insurer or health care center may submit an objection to the Insurance Commissioner concerning the proposed public health fee. The Insurance Commissioner, after making any

adjustment that said commissioner deems necessary, shall, not later than January first, annually, submit a final statement to each insurer and health care center that includes the final fee for the insurer or health care center. Each such insurer and health care center shall pay such fee to the Insurance Commissioner not later than February first, annually.

(e) Any such insurer or health care center aggrieved by an assessment levied under this section may appeal therefrom in the same manner as provided for appeals under section 38a-52.

(f) (1) The Insurance Commissioner shall apply an overpayment of the public health fee by an insurer or health care center for any fiscal year as a credit against the public health fee due from such insurer or health care center for the succeeding fiscal year, subject to an adjustment under subsection (c) of this section, if: (A) The amount of the overpayment exceeds five thousand dollars; and (B) on or before June first of the calendar year of the overpayment, the insurer or health care center (i) notifies the commissioner of the amount of the overpayment, and (ii) provides the commissioner with evidence sufficient to prove the amount of the overpayment.

(2) Not later than ninety days following receipt of notice and supporting evidence under subdivision (1) of this subsection, the commissioner shall (A) determine whether the insurer or health care center made an overpayment, and (B) notify the insurer or health care center of such determination.

(3) Failure of an insurer or health care center to notify the commissioner of the amount of an overpayment within the time prescribed in subdivision (1) of this subsection constitutes a waiver of any demand of the insurer or health care center against the state on account of such overpayment.

(4) Nothing in this subsection shall be construed to prohibit or limit the right of an insurer or health care center to appeal pursuant to subsection (e) of this section.

Sec. 33. Section 19a-7j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to any health and welfare fee due on or after February 1, 2017*):

(a) Not later than September first, annually, the Secretary of the Office of Policy and Management, in consultation with the Commissioner of Public Health, shall (1) determine the amount appropriated for the following purposes: (A) To purchase, store and distribute vaccines for routine immunizations included in the schedule for active immunization required by section 19a-7f; (B) to purchase, store and distribute (i) vaccines to prevent hepatitis A and B in persons of all ages, as recommended by the schedule for immunizations published by the National Advisory Committee for Immunization Practices, (ii) antibiotics necessary for the treatment of tuberculosis and biologics and antibiotics necessary for the detection and treatment of tuberculosis infections, and (iii) antibiotics to support treatment of patients in communicable disease control clinics, as defined in section 19a-216a; (C) to administer the immunization program described in section 19a-7f; and (D) to provide services needed to collect up-to-date information on childhood immunizations for all children enrolled in Medicaid who reach two years of age during the year preceding the current fiscal year, to incorporate such information into the childhood immunization registry, as defined in section 19a-7h, (2) calculate the difference between the amount expended in the prior fiscal year for the purposes set forth in subdivision (1) of this subsection and the amount of the appropriation used for the purpose of the health and welfare fee established in subparagraph (A) of subdivision (2) of subsection (b) of this section in that same year, and (3) inform the Insurance Commissioner of such amounts.

(b) (1) As used in this subsection, (A) "health insurance" means health insurance of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, and (B) "exempt insurer" means a domestic insurer that administers self-insured health benefit plans and is exempt from third-party administrator licensure under subparagraph (C) of subdivision (11) of section 38a-720 and section 38a-720a.

(2) (A) Each domestic insurer or domestic health care center doing health insurance business in this state shall annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under section 38a-52a, a health and welfare fee assessed by the Insurance Commissioner pursuant to this section.

(B) Each third-party administrator licensed pursuant to section 38a-720a that provides administrative services for self-insured health benefit plans and each exempt insurer shall, on behalf of the self-insured health benefit plans for which such third-party administrator or exempt insurer provides administrative services, annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under section 38a-52a, a health and welfare fee assessed by the Insurance Commissioner pursuant to this section.

(3) Not later than September first, annually, each such insurer, health care center, third-party administrator and exempt insurer shall report to the Insurance Commissioner, on a form designated by said commissioner, the number of insured or enrolled lives in this state as of May first immediately preceding for which such insurer, health care center, third-party administrator or exempt insurer is providing health insurance or administering a self-insured health benefit plan that provides coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469. Such number shall not include lives enrolled in Medicare, any medical assistance program administered by the Department of Social Services, workers' compensation insurance or Medicare Part C plans.

(4) Not later than November first, annually, the Insurance Commissioner shall determine the fee to be assessed for the current fiscal year against each such insurer, health care center, third-party administrator and exempt insurer. Such fee shall be calculated by multiplying the number of lives reported to said commissioner pursuant to subdivision (3) of this subsection by a factor, determined annually by said commissioner as set forth in this subdivision, to fully fund the amount determined under subsection (a) of this section,

adjusted for a health and welfare fee, by subtracting, if the amount appropriated was more than the amount expended or by adding, if the amount expended was more than the amount appropriated, the amount calculated under subdivision (2) of subsection (a) of this section. The Insurance Commissioner shall determine the factor by dividing the adjusted amount by the total number of lives reported to said commissioner pursuant to subdivision (3) of this subsection.

(5) (A) Not later than December first, annually, the Insurance Commissioner shall submit a statement to each such insurer, health care center, third-party administrator and exempt insurer that includes the proposed fee, identified on such statement as the "Health and Welfare fee", for the insurer, health care center, third-party administrator or exempt insurer calculated in accordance with this subsection. Each such insurer, health care center, third-party administrator and exempt insurer shall pay such fee to the Insurance Commissioner not later than February first, annually.

(B) Any such insurer, health care center, third-party administrator or exempt insurer aggrieved by an assessment levied under this subsection may appeal therefrom in the same manner as provided for appeals under section 38a-52.

(6) Any insurer, health care center, third-party administrator or exempt insurer that fails to file the report required under subdivision (3) of this subsection shall pay a late filing fee of one hundred dollars per day for each day from the date such report was due. The Insurance Commissioner may require an insurer, health care center, third-party administrator or exempt insurer subject to this subsection to produce the records in its possession, and may require any other person to produce the records in such person's possession, that were used to prepare such report, for said commissioner's or said commissioner's designee's examination. If said commissioner determines there is other than a good faith discrepancy between the actual number of insured or enrolled lives that should have been reported under subdivision (3) of this subsection and the number actually reported, such insurer, health

care center, third-party administrator or exempt insurer shall pay a civil penalty of not more than fifteen thousand dollars for each report filed for which said commissioner determines there is such a discrepancy.

(7) (A) The Insurance Commissioner shall apply an overpayment of the health and welfare fee by an insurer, health care center, third-party administrator or exempt insurer for any fiscal year as a credit against the health and welfare fee due from such insurer, health care center, third-party administrator or exempt insurer for the succeeding fiscal year, subject to an adjustment under subdivision (4) of this subsection, if: (i) The amount of the overpayment exceeds five thousand dollars; and (ii) on or before June first of the calendar year of the overpayment, the insurer, health care center, third-party administrator or exempt insurer (I) notifies the commissioner of the amount of the overpayment, and (II) provides the commissioner with evidence sufficient to prove the amount of the overpayment.

(B) Not later than ninety days following receipt of notice and supporting evidence under subparagraph (A) of this subdivision, the commissioner shall (i) determine whether the insurer, health care center, third-party administrator or exempt insurer made an overpayment, and (ii) notify the insurer, health care center, third-party administrator or exempt insurer of such determination.

(C) Failure of an insurer, health care center, third-party administrator or exempt insurer to notify the commissioner of the amount of an overpayment within the time prescribed in subparagraph (A) of this subdivision constitutes a waiver of any demand of the insurer, health care center, third-party administrator or exempt insurer against the state on account of such overpayment.

(D) Nothing in this subdivision shall be construed to prohibit or limit the right of an insurer, health care center, third-party administrator or exempt insurer to appeal pursuant to subparagraph (B) of subdivision (5) of this section.

Sec. 34. Section 38a-18 of the general statutes is repealed. (*Effective July 1, 2017*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2017*	New section
Sec. 2	*July 1, 2017*	38a-91dd
Sec. 3	*July 1, 2017*	38a-91rr
Sec. 4	*October 1, 2017*	New section
Sec. 5	*July 1, 2017*	38a-177
Sec. 6	*October 1, 2017*	38a-323
Sec. 7	*July 1, 2017*	38a-930(a)
Sec. 8	*July 1, 2017*	38a-140(b)
Sec. 9	*July 1, 2017*	38a-395(d)
Sec. 10	*July 1, 2017*	38a-479aa
Sec. 11	*July 1, 2017*	9-601(8)
Sec. 12	*July 1, 2017*	10a-178(g)
Sec. 13	*July 1, 2017*	12-202a(a)
Sec. 14	*July 1, 2017*	38a-71(a)(1)(G)
Sec. 15	*July 1, 2017*	38a-175(9)
Sec. 16	*July 1, 2017*	38a-176(b)(2)
Sec. 17	*July 1, 2017*	38a-178
Sec. 18	*July 1, 2017*	38a-179(a)
Sec. 19	*July 1, 2017*	38a-180(a) and (b)
Sec. 20	*July 1, 2017*	38a-181
Sec. 21	*July 1, 2017*	38a-182(a)
Sec. 22	*July 1, 2017*	38a-183(a)(1)
Sec. 23	*July 1, 2017*	38a-184
Sec. 24	*July 1, 2017*	38a-185
Sec. 25	*July 1, 2017*	38a-187
Sec. 26	*July 1, 2017*	38a-188
Sec. 27	*July 1, 2017*	38a-189
Sec. 28	*July 1, 2017*	38a-190
Sec. 29	*July 1, 2017*	38a-191
Sec. 30	*July 1, 2017*	38a-192
Sec. 31	*from passage*	38a-472f(a)(6)
Sec. 32	*from passage and applicable to any public health fee due on or after February 1, 2017*	19a-7p

Sec. 33	*from passage and applicable to any health and welfare fee due on or after February 1, 2017*	19a-7j
Sec. 34	*July 1, 2017*	Repealer section

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill as amended contains the following provisions:

1. Sections 1-3 reduce the minimum capital requirements for captive insurance companies and clarify certain asset and creditor recourse procedures resulting in no fiscal impact.

2. Sections 4-8 and 34 authorize the sale of short-term care group insurance policies in the state and make a variety of other insurance related changes resulting in no fiscal impact to the state.

3. Sections 9-31 increases the minimum net worth requirements for preferred provider networks and makes minor and technical changes to insurance-related statutes resulting in no fiscal impact to the state.

4. Sections 32-33 create a process for insurance companies and health care centers to seek reimbursement for overpayments that exceed $5,000 of the public health fee and/or health and welfare fee and results in no fiscal impact to the state. An overpayment will not be refunded to a company but rather treated as an adjustment that will be taken into account when the Department calculates the fee for the upcoming year.

House amendment "A" strikes the underlying bills fiscal impact and results in the fiscal impact described above.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sHB-7183 (as amended by House "A")*

AN ACT LOWERING THE MINIMUM UNIMPAIRED PAID-IN CAPITAL AND SURPLUS REQUIREMENT FOR SPONSORED CAPTIVE INSURANCE COMPANIES.

TABLE OF CONTENTS:

§ 9 — ANNUAL MALPRACTICE CLOSED CLAIM REPORT DUE DATE
Delays the due date of the commissioner's annual medical malpractice closed claims report

§ 10 — PREFERRED PROVIDER NETWORK (PPN) SOLVENCY AND LICENSING
Increases financial solvency requirements for PPNs and changes certain licensing dates

§§ 11-30 — TECHNICAL CHANGES
Makes technical and conforming changes throughout the HMO statutes

§ 31 — DENTAL AND VISION CARRIERS
Requires dental and vision carriers to abide by network adequacy requirements

§§ 32 & 33 — OVERPAYMENT OF PUBLIC HEALTH AND HEALTH AND WELFARE FEES
Requires insurance commissioner to return, in the form of a credit, certain fee overpayments

SUMMARY

This bill makes various changes to insurance laws. Among other things it

1. allows the insurance commissioner to waive capital and paid-in surplus requirements for certain captive insurers and lowers the minimum surplus requirements for sponsored captives (§ 2),
2. establishes group short-term care insurance policies (§ 4),
3. establishes "dormant captive insurers" and allows them to apply for a certificate of dormancy (§ 1),
4. increases the financial solvency requirements for PPNs (§ 10),
5. requires dental and vision insurance carriers to follow network adequacy requirements (§ 31), and
6. requires the insurance commissioner to credit overpayments of the public health and health and welfare fees (§§ 32 & 33).

The bill also makes other minor, technical, and conforming changes.

*House Amendment "A" strikes the underlying bill, which reduced the minimum capital and surplus requirements for sponsored captive insurers.

EFFECTIVE DATE: Various; see below.

§ 1 — DORMANT CAPTIVE INSURERS

Allows a domiciled dormant captive insurer to apply to the insurance commissioner for certificate of dormancy

Under the bill, a "dormant captive insurer" is a pure, sponsored, or industrial insured captive insurer that ceased transacting insurance business and has no insurance liabilities that occurred, or insurance policies issued, before, during, or after it files an application for a certificate of dormancy. Dormant captives may apply for a certificate of dormancy, which must be renewed every two years and is void if the insurer (1) fails to renew it or (2) conducts insurance business. (It is unclear how a dormant captive insurer reapplies to resume conducting insurance business.)

Generally, a captive insurer is an insurance company or entity formed to insure or reinsure the risk of its owner, parent company, or affiliated company.

Certificate of Dormancy

The bill requires a dormant captive insurer that receives a certificate of dormancy to possess and maintain unimpaired, paid-in capital and surplus of at least $25,000 and pay the license renewal fee for a pure, sponsored, or industrial captive, respectively. (Renewal license fees are set by law and vary based on the type of license.)

Connecticut requires capital and surplus to be "unimpaired and paid-in," which generally consists of the paid-in balance of shares plus undivided earnings.

Dormant captive insurers must also, by March 15 annually, submit to the commission a report on the dormant captive's financial condition in a form and manner she prescribes. The report must be verified by two executive officers' oaths.

EFFECTIVE DATE: July 1, 2017

§ 2 — UNIMPAIRED PAID-IN CAPITAL AND SURPLUS FOR SPONSORED CAPTIVE INSURERS

Reduces the amount of unimpaired and paid-in capital and surplus a sponsored captive insurer must maintain; allows the commissioner to reduce other captive surplus requirements

The bill reduces the amount of unimpaired and paid-in capital and surplus a sponsored captive insurer must maintain to obtain a license from the insurance commissioner from $500,000 to $225,000. By law, a sponsored captive insurance company is a captive insurance company (1) in which the minimum paid-in capital and surplus is provided by one or more sponsors, (2) that insures its participants through separate participant contracts, and (3) that funds its liability to each participant through protected cells and separates each cell's assets from the assets of other cells and the captive insurer as a whole.

The bill also allows the commissioner, at her discretion, to allow any type of captive insurer, except a risk retention group, to maintain less than the required unimpaired paid-in capital and surplus. In doing so, the commissioner must consider the type, volume, and the insurer or reinsurer's nature and business. (A risk retention group is a corporation or other limited liability association, often a captive insurer, formed under the federal Liability Risk Retention Act to assume and distribute the risk exposure of its members.)

EFFECTIVE DATE: July 1, 2017

§ 3 — SPONSORED CAPTIVES

Keeps independent the assets of individual cells of a sponsored captive

The bill establishes additional processes for maintaining the independence of separate "cells" (see below) during the conservation, rehabilitation, or liquidation of a sponsored captive insurance company. In general, these situations are governed by the state Insurers Rehabilitation and Liquidation Act.

By law, a sponsored captive funds its liability to each participant through protected "cells," with each cell's assets independent from those of other cells. Under the bill, a sponsored captive's assets and

liabilities must, at all times during a conservation, rehabilitation, or liquidation, be kept separate from the assets and liabilities of other protected cells or the sponsored captive. The bill removes provisions allowing cells to be independent to the extent determined by the commissioner.

The bill also prohibits a sponsored captive insurer's general account assets from being used to pay any expense or claim attributable solely to one or more of its protected cells unless the sponsor consents and the commissioner has granted prior written approval. If a sponsored captive insurer's general account assets are used to pay such expenses, the sponsor or sponsors cannot be required to contribute additional capital and surplus to the captive's general account. Under the bill, the sponsor must still satisfy the minimum capital and surplus required to maintain its license and the sponsored captive's capital and surplus must be available at all times to pay its expenses or claims.

Creditors

A creditor of a protected cell has recourse against that cell's assets but not against assets attributable to another cell or in the captive's general account. Under the bill, a sponsored captive's obligation to a creditor extends only to the protected cell's assets, and not to any other cell's assets or the sponsored captive's general account. Creditors only have recourse against the cell's assets and not against other cells or the insurer's general account. However, if a creditor has an obligation relating solely to the sponsored captive's general account, the creditor must be entitled to recourse against that account.

The bill specifies that establishing protected cells, by itself, does not constitute (1) fraudulent conveyance, (2) evidence of intent to defraud creditors, or (3) the conduct of business by a sponsored captive insurer for any other fraudulent purposes.

EFFECTIVE DATE: July 1, 2017

§ 4 — SHORT-TERM CARE INSURANCE POLICIES

Authorizes group short-term care insurance policies

The bill establishes group "short-term care" insurance policies and creates filing, disclosure, and other requirements identical to those currently required of individual short-term care policies. These policies provide coverage for 300 days or less, on an expense-incurred, indemnity, or prepaid basis, for necessary care or treatment of an injury, illness, or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital. They do not include policies primarily providing (1) supplemental Medicare coverage (i.e., Medigap coverage) or (2) coverage for basic medical-surgical expenses, hospital confinement indemnities, major medical expenses, disability income protection, accidents only, specified accidents, or limited benefits.

FILING REQUIREMENTS

The bill requires insurers and other entities (fraternal benefit societies, hospital service corporations, medical service corporations, and health care centers) to file copies of short-term care insurance policy forms, risk classifications, and premium rates with the insurance commissioner before delivering or issuing them to Connecticut residents. It also requires the insurance commissioner to adopt regulations establishing review procedures for these policies. ("Form" includes policies, riders, and endorsements.)

Disapproving Forms

Under the bill, the commissioner must reject any forms that (1) do not comply with the law, (2) contain unfair or deceptive provisions, or (3) contain provisions that misrepresent the policy. In such cases, she must notify the insurer in writing, specifying the reasons for her disapproval and ordering that no short-term care insurer deliver or issue a Connecticut policy on, or containing, the disapproved form.

Any insurer disagreeing with the commissioner may request a hearing under existing insurance provisions.

Approval of Rate Filings

The commissioner must adopt regulations ensuring that rates are not excessive, inadequate, or unfairly discriminatory. Rates are not effective until she approves them in accordance with these regulations, and the bill authorizes her to disapprove rates failing to meet the standards in the regulations.

Required Disclosure

The bill prohibits insurers and other issuing entities from issuing or delivering a short-term care policy without first providing, at the time of solicitation or application, a full and fair written disclosure of the policy's benefits and limitations. For short-term care policies with premium rate revisions or rate schedule increases, the disclosure must include:

1. a statement, in at least 12-point bold face type, that the policy does not provide long-term care insurance coverage and is not a long-term care insurance policy or a Connecticut Partnership for Long-Term Care insurance policy;

2. a statement that the policy may be subject to future rate increases, including an explanation of potential future premium rate revisions and the policyholder's subsequent options; and

3. the premium rate or rate schedule that is applicable to the applicant until the issuer files a request with the commissioner for a premium rate or rate schedule revision.

Applicants must sign an acknowledgment, at the time of the application, that the insurer or other issuing entity has disclosed this information. If the application method does not allow for a signature (e. g., an electronic application), the applicant must sign an acknowledgement before the policy is delivered.

Regulations

The bill requires the commissioner to adopt implementing regulations for short-term care insurance policies, including (1) permissible loss ratios and exclusionary periods, (2)circumstances

when a policy is renewable, and (3) the benefits payable in relation to an insured's other insurance coverage.

Managed Residential Communities

The bill prohibits insurers and other entities from refusing to accept or reimburse short-term care insurance claims submitted by, or prepared with the help of, a managed residential community solely because the community submits or prepares the claim. Upon an insured's written request, these issuing entities must also (1) disclose to an insured's managed care community the insured's coverage eligibility and (2) provide the community with a copy of an initial claim acceptance or denial at the same time they provide one to the insured.

EFFECTIVE DATE: October 1, 2017

§ 5 — HEALTH CARE CENTERS

Allows health care centers (i.e., HMOs) to offer additional methods of health care, including by charging coinsurance

Under current law, health care centers (i.e., HMOs) may provide health care (1) directly or indirectly and (2) by methods permitted under the federal Health Maintenance Organization Act unless otherwise determined by regulation. The HMO Act, among other things, requires, payments by insureds to be fixed without regard to the frequency, extent, or kind of health service received.

The bill instead allows HMOs to offer health care services (1) directly or indirectly, or (2) by methods permitted under the act unless otherwise determined by regulation.

EFFECTIVE DATE: July 1, 2017

§ 6 — PERSONAL AND COMMERCIAL RISK INSURANCE DISCLOSURES

Requires an insurer to disclose certain comparative information before renewing a personal or commercial risk insurance policy with terms less favorable to the insured than his or her current policy

Under the bill, an insurer renewing a personal or commercial risk

insurance policy less favorable than an insured's current policy must send a conditional renewal notice clearly identifying any reduction in coverage limits and any added or revised coverage provisions that reduce coverage or increase deductibles.

By law, renewal notices must be sent by registered or certified mail, or proven by a certificate of mailing, to the address shown in the policy at least 60 days before renewal.

EFFECTIVE DATE: October 1, 2017

§ 7 — COMMUTATION REINSURANCE AGREEMENTS

Prohibits an insurer's liquidator from voiding commutation reinsurance agreements approved by the commissioner

Under current law, an insurer in hazardous financial condition or that meets certain other criteria may be placed under the insurance commissioner's supervision. If the supervised insurer is liquidated, the court-appointed liquidator (e.g., the commissioner) may void certain transfers that unfairly benefit some creditors over others, as long as the transfers are made:

1. within one year of the liquidation date or

2. for insurers already subject to a rehabilitation order, within two years of the rehabilitation petition or one year from the liquidation petition, whichever is shorter.

Under the bill, transfers under commutations of reinsurance agreements approved by the commissioner or her designee may not be voided. A commutation agreement eliminates all present and future reinsurance obligations between the parties in exchange for current consideration. (Reinsurance transfers one party's insurance risk to another party.)

EFFECTIVE DATE: July 1, 2017

§§ 8 & 34 — IRLA AND REPEALER

Allows the insurance commissioner to take possession of impaired insurers pursuant to the Insurers Rehabilitation and Liquidation Act (IRLA) and repeals an outdated receivership provision

The bill allows the commissioner to take possession of an insurer in certain situations, including insolvency, pursuant to the Insurers Rehabilitation and Liquidation Act (IRLA), instead of an outdated provision, and repeals the outdated provision (CGS § 38a-18). IRLA generally provides more detailed procedures for when and how the commissioner can supervise, rehabilitate, or liquidate an insurance company.

EFFECTIVE DATE: July 1, 2017

§ 9 — ANNUAL MALPRACTICE CLOSED CLAIM REPORT DUE DATE

Delays the due date of the commissioner's annual medical malpractice closed claims report

The bill delays the due date, from March 15 to June 30, of the commissioner's annual medical malpractice closed claims report to the Insurance and Real Estate Committee.

EFFECTIVE DATE: July 1, 2017

§ 10 — PREFERRED PROVIDER NETWORK (PPN) SOLVENCY AND LICENSING

Increases financial solvency requirements for PPNs and changes certain licensing dates

The bill increases the financial solvency requirements for a preferred provider network (PPN) by requiring that it maintain (a) a minimum net worth of $500,000, instead of $250,000, and (b) at least four months, instead of two months, worth of payments to participating providers.

Preferred Provider Network

By law, a PPN pays claims for the delivery of health care services; accepts financial risk for doing so; and establishes, operates, or maintains an arrangement or contract with providers relating to the services the providers render and the amounts they are paid. It does not include a managed care organization, workers' compensation preferred provider organization, independent practice association,

physician hospital organization, clinical laboratory, or pharmacy benefits manager.

Minimum Net Worth

By law, a PPN conducting business in Connecticut must maintain a specified minimum net worth. Current law requires it to maintain either (1) the greater of $250,000 or 8% of its annual expenditures or (2) another amount the insurance commissioner determines. The bill increases the first condition to $500,000.

The law also requires a PPN to maintain or arrange for a letter of credit, bond, surety, reinsurance, reserve, or other financial security acceptable to the commissioner for paying outstanding amounts owed to participating providers. Current law requires this to be the greater of:

1. two months of payments owed to participating providers based on the two months in the past year with the greatest amounts owed,

2. the actual outstanding amount owed to participating providers, or

3. another amount the commissioner determines.

The bill increases the first condition to four months of payments owed based on the four months in the past year with the greatest amounts owed.

Licensing Deadlines

The bill requires (1) PPNs to apply to be licensed by the insurance commissioner annually by May 1, instead of March 1, and (2) the commissioner to issue or renew PPN licenses annually by July 1, instead of May 1.

EFFECTIVE DATE: July 1, 2017

§§ 11-30 — TECHNICAL CHANGES

Makes technical and conforming changes throughout the HMO statutes

The bill makes technical and conforming changes throughout the HMO laws to specify that all HMOs are subject to all of the laws in Part I of Chapter 698a of the general statutes, including laws concerning insolvency.

EFFECTIVE DATE: July 1, 2017

§ 31 — DENTAL AND VISION CARRIERS

Requires dental and vision carriers to abide by network adequacy requirements

The bill requires dental and vision carriers to abide by the law's network adequacy requirements, which currently apply only to certain health carriers.

Network Adequacy Requirements

PA 16-205 (§ 1) requires carriers to establish and maintain adequate provider networks to assure that all covered benefits are accessible to covered individuals without unreasonable travel or delay. It requires that covered individuals have access to emergency services at all times.

The act also requires the insurance commissioner to review and determine the sufficiency of a carrier's provider network. Additionally, it requires a carrier to provide benefits at the in-network level of coverage when a nonparticipating provider performs covered services for a covered individual because a participating provider is not available in the network.

EFFECTIVE DATE: Upon passage

§§ 32 & 33 — OVERPAYMENT OF PUBLIC HEALTH AND HEALTH AND WELFARE FEES

Requires insurance commissioner to return, in the form of a credit, certain fee overpayments

By law, domestic insurers and health care centers must annually, by February 1, pay to the insurance commissioner a public health fee. These fees are used to pay for certain Department of Public Health programs, including a needle and syringe exchange program and a

breast and cervical cancer detection and treatment program. In addition, the law requires insurers, health care centers, third-party administrators, and exempt insurers to pay annually, by February 1, a health and welfare fee to the commissioner. These fees are used to, among other things, provide vaccines and antibiotics.

Under the bill, the commissioner must credit an overpayment towards the respective fee due the next fiscal year if the overpayment on the fee exceeds $5,000 and the entity (1) notifies the commissioner by June 1 of the overpayment amount and (2) provides sufficient evidence to prove the overpayment.

The commissioner must, within 90 days of receiving the notice and supporting evidence, determine and notify the insurer of whether it overpaid. Under the bill, failure to notify the commissioner by June 1 constitutes a waiver of any claim against the state for the overpayment. The bill specifies that it does not prohibit or limit an entity's appeal rights.

EFFECTIVE DATE: Upon passage and applicable to any fee due on or after February 1, 2017.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 21 Nay 0 (03/15/2017)